



**JOHN MARSHALL GRADY, DMD
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New Patient Health History

Patient Biographical Information			
First Name:		Middle Initial:	Last Name:
Birth date:		Age:	Social Security #:
Address:		City:	State:
Main Phone:		2 nd /Cell Phone:	Email:
Please list the names of any friends or family currently in the practice:			
List any sports, hobbies, or musical instruments played:			
How did you hear about our practice (check all that applies)?			
Community Event	School Visit	Angie's List	Facebook
Google	Yelp	Invisalign Website	Insurance Company
Magazine/Newspaper Advertisement		Family Member/Friend/Neighbor (If so, whom?)	
Dentist/ Dr. (If so, whom?)			

Financial Party Information			
Who is responsible for account?		Marital Status:	
		Single	Married
		Partnered	Widowed
		Divorced	Separated
Relation:	Mother	Father	Stepmother
Stepfather	Guardian	Spouse	Self
Parents	Grandparents	Other	
Name:	Birthdate:	Name:	Birthdate:
Address: (If different than Patient)		Address: (If different than Patient)	
SS #:		SS #:	
Employer:	Occupation:	Employer:	Occupation:
Orthodontic Coverage		Orthodontic Coverage	
Insurance Co. Name:		Insurance Co. Name:	
Insurance Co. Address:		Insurance Co. Address:	
Ins. Ph #:	Insured's ID #:	Ins. Ph #:	Insured's ID #:
Group # (Plan, Local or Policy #:		Group # (Plan, Local or Policy #:	

Authorization	
<p>This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance.</p>	
Signature: _____	Date: _____

Dental History					
Dentist Name:					
Check-up Frequency:			Last Dental Visit:		
Has the patient had an orthodontic consult or treatment?				If so, when?	
What is the patient's main orthodontic concern?					
Speech problems/therapy?	Yes	No	Brush teeth daily?	Yes	No
Grind or clench teeth?	Yes	No	Floss teeth daily?	Yes	No
Oral habits (thumb/finger habit, lip/nail biting)?	Yes	No	Fluoride treatments?	Yes	No
Injury to face, jaw, teeth, or mouth?	Yes	No	Sleep with mouth open?	Yes	No
Discomfort from teeth or gums?	Yes	No	Snores during sleep?	Yes	No
Pain, tenderness, or noise in either jaw?	Yes	No	Requires premedication?	Yes	No
Frequent headaches?	Yes	No	Any missing or extra permanent teeth?	Yes	No
Neck/shoulder pain?	Yes	No	Apprehensive about dental care?	Yes	No
Frequent sore throats?	Yes	No	Frequently chews gum?	Yes	No
If any of the above dental questions were answered "Yes," please explain:					

Medical History					
Physician Name:		Date of last Physical:		Patient Health:	
Address:		City:	State:		Zip:
List any medications currently being taken by the patient:					
List any drug allergies or sensitivities that the patient may have:					
Rheumatic Fever	Yes	No	Cancer	Yes	No
Tuberculosis/Lung Disease	Yes	No	Family History of Cancer	Yes	No
Pneumonia	Yes	No	Received Radiation Treatment	Yes	No
Liver Disease	Yes	No	Growth Problems	Yes	No
Kidney Disease	Yes	No	Endocrine Problems	Yes	No
Heart Attack/Stroke	Yes	No	Hormone Therapy	Yes	No
Heart Disease	Yes	No	Latex/Metal Allergy	Yes	No
Congenital Heart Defect	Yes	No	Nervous Disorders	Yes	No
Heart Murmur	Yes	No	Bone Disorders/Bone Loss	Yes	No
Hemophilia	Yes	No	Diabetes	Yes	No
Hypertension/High Blood Pressure	Yes	No	Seizures/Epilepsy	Yes	No
Prolonged Bleeding/Transfusion	Yes	No	Handicaps/Disabilities	Yes	No
Anemia	Yes	No	Asthma	Yes	No
HIV/AIDS	Yes	No	Arthritis	Yes	No
Hepatitis	Yes	No	Treated for Emotional Problems	Yes	No
Tonsils/Adenoids Removed	Yes	No	Ever Been Hospitalized	Yes	No
If any of the above medical questions were answered "Yes," please explain:					

Patients Under 18			
Height:	Weight:	School:	Grade:
Father/Guardian 1 Name:		Mother/Guardian 2 Name:	
Has patient begun puberty?			Yes No
If patient is a girl, has menstruation begun?			Yes No
If patient is a boy, has their voice changed or have facial hair?			Yes No
Has the patient grown in the past year or has their shoe size changed recently?			Yes No
Please list the name and birth date of any siblings:			

Airway History			
Patients Age:	For internal use only:	Exp	Non-exp
Sex:	Account Number:	Initial	Final
If this patient is under the age of 18 please answer the following questions:			
While sleeping, does your child ...			
...snore more than half the time?		Yes	No Don't Know
...always snore?		Yes	No Don't Know
...snore loudly?		Yes	No Don't Know
...have "heavy" or loud breathing?		Yes	No Don't Know
...have trouble breathing, or struggle to breathe?		Yes	No Don't Know
Have you ever seen your child stop breathing during the night?		Yes	No Don't Know
Does your child...			
...tend to breathe through the mouth during the day?		Yes	No Don't Know
...have a dry mouth on waking up in the morning?		Yes	No Don't Know
...occasionally wet the bed?		Yes	No Don't Know
Does your child...			
...wake up feeling <i>un</i> -refreshed in the morning?		Yes	No Don't Know
...have problem with sleepiness during the day?		Yes	No Don't Know
Has a teacher or other supervisor commented that your child appears sleepy during the day?		Yes	No Don't Know
Is it hard to wake your child up in the morning?		Yes	No Don't Know
Does your child wake up with headaches in the morning?		Yes	No Don't Know
Did your child stop growing at a normal rate at any time since birth?		Yes	No Don't Know
Is your child overweight?		Yes	No Don't Know
This child often does not seem to listen when spoken to directly.		Yes	No Don't Know
This child often has difficulty organizing tasks and activities.		Yes	No Don't Know
This child is often easily distracted by extraneous stimuli.		Yes	No Don't Know
This child often fidgets with hands or feet or squirms in seat.		Yes	No Don't Know
This child is often "on the go" or often acts as if "driven by a motor."		Yes	No Don't Know
This child often interrupts or intrudes on others (e.g. butts into conversations or games)		Yes	No Don't Know
Have your child's tonsils/adenoids been removed?		Yes	No Don't Know
And if so, when?			

To the best of my knowledge all above information is correct and it is my responsibility to inform the office of any changes in medical history. I also authorize the dental staff to perform the necessary orthodontic services. If Airway History is filled out, I consent to the collection of my child's breathing data along with photos and full orthodontic records for use in scientific research and analysis? If so, please sign below. Thank you.

Parent/Patient Signature: _____ Date: _____

I verbally reviewed the medical/dental information above with the patient.

Doctor Signature: _____ Date: _____